2010 - 2011 Insurance and Vaccine Administration Record

Information about the person to receive vaccine (please print): *Required Fields

Name: (Last, First, MI)*	Date of birth: * _____ ____ _____ Month Day Year	Age*	Sex: (Circle)* Male Female
Street Address:*			
City:*	State: *	Zip:*	Phone:* ( )

Insurance Information: *Include the whole member ID number and any letters that are part of that number*

Name of Insurance Company:*	Member ID Number:*	Group ID Number: (if available)

If person getting vaccinated is not the subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: * _____ ____ _____ Month Day Year	Sex: (Circle)* Male Female
Subscriber's Street Address:* (If different from address above)		
City:*	State:*	Zip: *	Phone:* ( )
Patient Relationship to Subscriber: (Circle)* Spouse Child Other		

I give permission for vaccine and for my insurance company to be billed.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

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For Clinic/Office Use Only:

Date vax given:	Seasonal Flu Vax Type	Vax Manufacturer	Vax Exp. Date & Lot No.	Dose No.	Injection Site & Route: (Circle)*	Date on VIS	Date VIS Given
	INJ MIST			Dose #1 Dose #2	Intranasal IM R Arm L Arm R Leg L Leg	08-10-10	

Clinic Site Name: **Westford Health Department** MDPH Provider PIN#: **11994**

Clinic Address: **55 Main Street Westford, MA 01886**

Signature of Vaccine Administrator: _____ Date: _____